DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-21

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT
a. FFY 02 $7,114,000
b. FFY 03 $28,456,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19b, Pages 3, 4, 5, 6, ,8

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19b, Pages 3, 4, 5, 6, 8

10. SUBJECT OF AMENDMENT:

Outpatient Hospital Services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:
Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: Jackie Garner

13. TYPED NAME: **Jackie Garner**

14. TITLE: **DIRECTOR**

15. DATE SUBMITTED

16. RETURN TO:

ILLINOIS DEPARTMENT OF PUBLIC AID
201 SOUTH GRAND AVENUE, EAST
SPRINGFIELD, IL. 62763-0001
ATTENTION: John Rupcich

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 8/16/02

18. DATE APPROVED: 10/23/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL: Cheryl A. Harris

21. TYPED NAME: Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

FORM HCFA-179 (07-92) *Instructions on Back*

RECEIVED
AUG 16 2002
DMCH - IL/IN/OH

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

i. APL Groupings

Under the APL, a list was developed that defines those technical procedures that require the use of the hospital outpatient setting, its technical staff or equipment. These procedures are separated into ~~four~~ separate groupings based upon the complexity and historical costs of the procedures. The groupings are as follows:

1/02 A. Surgical Groups

07/98

1. Surgical group 1.a. consists of intense surgical procedures. Group 1 .a. surgeries require an operating suite with continuous patient monitoring by anesthesia personnel. This level of service involves advanced specialized skills and highly technical operating room personnel using high technology equipment. The rate for Surgical group 1.a. through June 30, 2002, is $1,336. The rate effective July 1, 2002, is $1,794.

2. Surgical group 1.b. consists of moderately intense surgical procedures. Group 1.b. surgeries generally require the use of an operating room suite or an emergency room treatment suite, along with continuous monitoring by anesthesia personnel and some specialized equipment. The rate for Surgical groub 1.b. through June 30, 2002, is $781. The rate effective July 1, 2002, is $1,049.

3. Surgical group 1.c. consists of low intensity surgical procedures. Group 1.c. surgeries may be done in an operating suite or an emergency room and require relatively brief operating times. Such procedures may be performed for evaluation or diagnostic reasons. The rate for Surgical group 1.c .through June 30, 2002, is $560. The rate effective July 1, 2002, is $752.

4. Surgical group 1.d. consists of surgical procedures of very low intensity. Group 1.d. surgeries may be done in an operating room or emergency room, have a low risk of complications, and include some physician-administered diagnostic and therapeutic procedures. The rate for Surgical group 1.d. through June 30, 2002, is $214. The rate effective July 1, 2002, is $287.

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7/02 B. Diagnostic and Therapeutic Groups

1. Diagnostic and therapeutic group 2.a. consists of advanced or evolving technologically complex diagnostic or therapeutic procedures. Group 2.a. procedures are typically invasive and must be administered by a physician. The rate for Diagnostic and therapeutic group 2.a. through June 30, 2002, is $701. The rate effective July 1, 2002, is $941.

2. Diagnostic and therapeutic group 2.b. consists of technologically complex diagnostic and therapeutic procedures that are typically non-invasive. Group 2.b. procedures typically include radiological consultation or a diagnostic study. The rate for Diagnostic and therapeutic group 2.b. through June 30, 2002, is $226. The rate effective July 1, 2002, is $304.

3. Diagnostic and therapeutic group 2.c. consists of other diagnostic tests. Group 2.c. procedures are generally non-invasive and may be administered by a technician and monitored by a physician. The rate for Diagnostic and therapeutic group 2.c.through June 30, 2002, is $131. The rate effective July 1, 2002, is $176.

4. Diagnostic and therapeutic group 2.d. consists of therapeutic procedures. Group 2.d. procedures typically involve parenterally administered therapeutic agents. Either a nurse or a physician is likely to perform such procedures. The rate for Diagnostic and therapeutic group 2.d. through June 30, 2002, is $101. The rate effective July 1, 2002, is $136.

1/02 C. Group 3 includes reimbursement for services provided in a hospital emergency department that will be made in accordance with one of the three levels described below. Emergency Services mean those services which are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions

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1/02 or serious dysfunction of any bodily organ part. The determination of the level of service reimbursable by the Department shall be based upon the circumstances at the time of the initial examination, not upon the final determination of the client's actual condition, unless the actual condition is more severe.

7/02 1. Emergency Level I refers to Emergency Services provided in the hospital's emergency department for the alleviation of severe pain or for immediate diagnosis or treatment of conditions or injuries which pose an immediate significant threat to life or physiologic function. The rate for Emergency Level I through June 30, 2002, is $135. The rate effective July 1, 2002, is $181.

7/02 2. Emergency Level II refers to Emergency Services that do not meet the above definition of Emergency Level I care, but which are provided in the hospital emergency department for a medical condition manifesting itself by acute symptoms of sufficient severity. The rate for Emergency Level II through July 1, 2002, is $50. The rate effective July 1, 2002, is $67.

7/02 3. Non-Emergency/Screening Level means those services provided in the hospital emergency department that do not meet the requirements of Emergency Levels I or II stated above. For such care, the hospital has a choice to bill the Department either the applicable current FFS rates for the services provided or a screening fee, but not both. The rate for the screening fee is based on periodic negotiations with representatives of the hospital industry. The rate for Non-Emergency/Screening Level through June 30, 2002 is $19. The rate effective July 1, 2002 is $26.

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D. Group 4 for observation services is established to reimburse such services that are provided when a patient's current condition does not warrant an inpatient admission but does require an extended period of observation in order to evaluate and treat the patient in a setting which provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care. The hospital may bill for both observation and other APL procedures but will be reimbursed only for the procedure (group) with the highest reimbursement rate. *Observation services will be reimbursed under one of three categories:* at least one hour but less than six hours and thirty-one minutes of services, at a rate of $55 through June 30, 2002. Effective July 1, 2002, the rate is $74; at least six hours and thirty-one minutes but less than twelve hours and thirty-one minutes of services, at a rate of $165 through June 30, 2002. Effective July 1, 2002, the rate is $222; or, twelve hours and thirty-one minutes of services or more at a rate of $330 through June 30, 2002. Effective July 1, 2002, the rate is $443.

7/02

E. Group 5 for psychiatric treatment services is established to reimburse for certain outpatient treatment psychiatric services that are provided by a hospital that is enrolled with the Department to provide inpatient psychiatric services. Under this group, the Department will reimburse Type A and Type B Psychiatric Clinic Services at a rate of $62 through June 30, 2002. Effective July 1, 2002, the rate is $68 for Type A and $101 for Type B services, as defined in the Illinois Administrative Code at 89 Ill. Adm. Code Section 148.40.d.2. and the Illinois Medicaid State Plan. A rate of $102 will also be reimbursed to children's hospitals as defined in 89 Ill. Adm. 149.50(c)(3) and Attachment 4.19A. Chapter 11.C.3 in the Illinois Medicaid State Plan. The rate for such services is based on periodic negotiations with representatives of the hospital industry.

7/02

F. Group 6 for physical rehabilitation services is established to reimburse for certain outpatient physical rehabilitation services.—Under this group, the Department will reimburse for services provided by a general care hospital not enrolled with the Department to provide ~~inpatient~~ outpatient physical rehabilitation services at a rate of $115. For physical rehabilitation services provided by a hospital that is enrolled with the Department that provides specialized physical rehabilitation services the rate is $115 through June 30, 2002. Effective July 1, 2002, the rate is $130. The rate for such services is based on periodic negotiations with representatives of the hospital industry. A ~~different~~ rate of $130 will be reimbursed to children's hospitals as defined in 89 Ill. Adm. 149.50(c)(3) and Attachment 4.19A. Chapter 11.C.3 in the Illinois Medicaid State Plan. The rate for such services is based on periodic negotiations with representatives of the hospital industry.

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7/02 E. For county-owned hospitals located in an Illinois county with a population greater than three million, reimbursement rates for each of the reimbursement groups shall be equal to the amounts described in section (i). above, multiplied by a factor of ~~3.65~~ 2.72. except that physical rehabilitation services provided by a general care hospital not enrolled with the Department to provide ~~inpatient~~ outpatient physical rehabilitation services shall be reimbursed at a rate of $230 ~~$370.00~~ and the reimbursement for type B psychiatric clinic services shall be $224. However, such rates shall be no lower than the rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

07/01 F. Reimbursement for each APL group described in subsection b.i. shall be all-inclusive for all services provided by the hospital. No separate reimbursement will be made for ancillary services or the services of hospital personnel. Exceptions to this provision are that hospitals shall be allowed to bill separately, on a fee-for-service basis, for professional outpatient services of a physician providing direct patient care who is salaried by the hospital, and occupational or speech therapy services provided in conjunction with rehabilitation services as described in subsection .b.i. of this Section. For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide emergency department care. Under APL reimbursement, salaried physicians do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists and no separate reimbursement will be allowed for such providers.

07/99 G. The Department of Public Aid will reimburse ambulatory surgical treatment centers (ASTCs) for facility services in accordance with covered APL groups as defined in this section. The Department may exclude from coverage in an ASTC any procedure identified as only appropriate for coverage in a hospital setting. All groups that may be reimbursed to an ASCT are defined in the Department's hospital handbook and notices to providers. Reimbursement levels shall be the lower of the ASTC's usual and customary charge to the public or an all inclusive rate for facilty services, which shall be 75 percent of the applicable APL rate.